		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040816

Facility Name: Emerald Park Health Care Center

Address: 9125 South Pulaski Rd. (Number) Evergreen Park (City) 60642 (Zip Code)

County: Cook

Telephone Number: (708) 425-3400 **Fax #** (708) 425-5086

IDPA ID Number: 363473443001

Date of Initial License for Current Owners: 02/11/1987

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Sanford Alper **Telephone Number:** (847) 647-6600

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2000 to 12/31/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) Sanford Alper - Principal

Kessler, Orlean, Silver & Co. P.C.

(Firm Name & Address) 7400 N. Oak Park Ave.
Niles, IL 60714

(Telephone) (847) 647-6600 Fax # (847) 647-6600

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Emerald Park Health Care Center # 0040816 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 249

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	163	Skilled (SNF)	163	59,658	1
2		Skilled Pediatric (SNF/PED)			2
3	86	Intermediate (ICF)	86	31,476	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	249	TOTALS	249	91,134	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	83,200	2,127	1,487	86,814	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	83,200	2,127	1,487	86,814	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.26%

D. How many bed-hold days during this year were paid by Public Aid?
2,801 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/11/1987

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/1996 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 26 and days of care provided 1,324

Medicare Intermediary Mutual Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2000 Fiscal Year: 12/31/2000

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Emerald Park Health Care Center # 0040816 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	216,908	70,381	8,800	296,089		296,089		296,089			1
2	Food Purchase		268,869		268,869		268,869		268,869			2
3	Housekeeping	220,698	74,521		295,219		295,219		295,219			3
4	Laundry	67,932	21,525		89,457		89,457		89,457			4
5	Heat and Other Utilities			114,929	114,929		114,929		114,929			5
6	Maintenance	37,529		41,424	78,953		78,953		78,953			6
7	Other (specify):* Scavenger			9,071	9,071		9,071		9,071			7
8	**TOTAL General Services**	543,067	435,296	174,224	1,152,587		1,152,587		1,152,587			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,925,086	70,882	27,864	2,023,832		2,023,832		2,023,832			10
10a	Therapy	48,765		6,350	55,115		55,115		55,115			10a
11	Activities											11
12	Social Services	128,480		1,796	130,276		130,276		130,276			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,102,331	70,882	42,010	2,215,223		2,215,223		2,215,223			16
	C. General Administration											
17	Administrative	127,417		98,955	226,372		226,372	(98,955)	127,417			17
18	Directors Fees											18
19	Professional Services			155,269	155,269		155,269	(76,930)	78,339			19
20	Dues, Fees, Subscriptions & Promotions			27,247	27,247		27,247	(6,631)	20,616			20
21	Clerical & General Office Expenses	221,121	14,818	86,727	322,666		322,666	(48,932)	273,734			21
22	Employee Benefits & Payroll Taxes			441,960	441,960	(710)	441,250	16,102	457,352			22
23	Inservice Training & Education											23
24	Travel and Seminar					710	710		710			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			18,203	18,203		18,203		18,203			26
27	Other (specify):* Bad Debts			137,777	137,777		137,777	(137,777)				27
28	**TOTAL General Administration**	348,538	14,818	966,138	1,329,494		1,329,494	(353,123)	976,371			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,993,936	520,996	1,182,372	4,697,304		4,697,304	(353,123)	4,344,181			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Emerald Park Health Care Center #0040816 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			89,919	89,919		89,919	261,864	351,783			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							618,339	618,339			32
33	Real Estate Taxes			833,728	833,728		833,728	266,222	1,099,950			33
34	Rent-Facility & Grounds			273,422	273,422		273,422	(1,106,210)	(832,788)			34
35	Rent-Equipment & Vehicles			38,454	38,454		38,454		38,454			35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,235,523	1,235,523		1,235,523	40,215	1,275,738			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		8,413		8,413		8,413		8,413			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			135,977	135,977		135,977		135,977			42
43	Other (specify):*			200	200		200	(200)				43
44	**TOTAL Special Cost Centers**		8,413	136,177	144,590		144,590	(200)	144,390			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,993,936	529,409	2,554,072	6,077,417		6,077,417	(313,108)	5,764,309			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Emerald Park Health Care Center # 0040816 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	75,468	30		9
10	Interest and Other Investment Income	(15,856)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(42,240)	21		18
19	Entertainment				19
20	Contributions	(9,600)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(137,777)	27		24
25	Fund Raising, Advertising and Promotional	(6,631)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached Schedule	(121,867)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (258,503)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(54,605)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (54,605)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (313,108)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Emerald Park Health Care Center

ID# 0040816

Report Period Beginning: 01/01/2000

Ending: 12/31/2000

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Franchise Tax	$ (200)	43	1
2	Franchise Tax	(13)	43	2
3	Collections	(76,930)	19	3
4	Management Fees	(44,724)	17	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
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73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(121,867)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Emerald Park Health Care Center # 0040816 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(44,724)	(54,231)	0	0	0	0	0	0	0	0	0	(98,955)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(76,930)	0	0	0	0	0	0	0	0	0	0	(76,930)	19
20	Fees, Subscriptions & Promotions	(6,631)	0	0	0	0	0	0	0	0	0	0	(6,631)	20
21	Clerical & General Office Expenses	(51,840)	2,908	0	0	0	0	0	0	0	0	0	(48,932)	21
22	Employee Benefits & Payroll Taxes	0	16,102	0	0	0	0	0	0	0	0	0	16,102	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(137,777)	0	0	0	0	0	0	0	0	0	0	(137,777)	27
28	**TOTAL General Administration**	(317,902)	(35,221)	0	0	0	0	0	0	0	0	0	(353,123)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(317,902)	(35,221)	0	0	0	0	0	0	0	0	0	(353,123)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Emerald Park Health Care Center # 0040816 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	75,468	186,396	0	0	0	0	0	0	0	0	0	261,864	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(15,856)	634,195	0	0	0	0	0	0	0	0	0	618,339	32
33	Real Estate Taxes	0	266,222	0	0	0	0	0	0	0	0	0	266,222	33
34	Rent-Facility & Grounds	0	(1,106,210)	0	0	0	0	0	0	0	0	0	(1,106,210)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	59,612	(19,397)	0	0	0	0	0	0	0	0	0	40,215	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(213)	13	0	0	0	0	0	0	0	0	0	(200)	43
44	**TOTAL Special Cost Centers**	(213)	13	0	0	0	0	0	0	0	0	0	(200)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(258,503)	(54,605)	0	0	0	0	0	0	0	0	0	(313,108)	45

Facility Name & ID Number Emerald Park Health Care Center # 0040816 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Marvin Mermelstein	24.50%	Balmoral Nursing Home	Chicago	Nivram Mgmt., Inc.	Chicago	Nurs. Home Mgmt
Doreen Mermelstein	24.50%	Winston Manor Nursing Home	Chicago	EMI Enterprise, Inc.	Lincolnwood	Nurs. Home Mgmt
Morris Esformes	51.00%	Central Nursing Home	Chicago	M. Mermelstein Ptsp.	Chicago	Lessor
		Sovereign Healthcare, L.L.C.	Chicago			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	Bank Charges	$	Nivram Management, Inc.	24.50%	$ 13	$ 13	1
2	V	21	Office Expenses		Nivram Management, Inc.	24.50%	95	95	2
3	V	21	Supplies		Nivram Management, Inc.	24.50%	2,054	2,054	3
4	V	43	Franchise Tax		Nivram Management, Inc.	24.50%	13	13	4
5	V	22	Payroll Taxes		Nivram Management, Inc.	24.50%	16,102	16,102	5
6	V	21	Telephone		Nivram Management, Inc.	24.50%	746	746	6
7	V	17	Management Fees	54,231	Nivram Management, Inc.			(54,231)	7
8	V								8
9	V	30	Depreciation		M. Mermelstein Partnership	100.00%	186,396	186,396	9
10	V	32	Interest		M. Mermelstein Partnership	100.00%	634,195	634,195	10
11	V	33	Property Taxes		M. Mermelstein Partnership	100.00%	266,222	266,222	11
12	V	34	Rent	1,106,210	M. Mermelstein Partnership	100.00%		(1,106,210)	12
13	V								13
14	Total			$ 1,160,441			$ 1,105,836	$ * (54,605)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Emerald Park Health Care Center # 0040816 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	Marvin Mermelstein	Asst. Administrator	Administrative	24.50%	145,360	13	16.00%	Salary	$ 36,340	L 17, C 1	1
2	Marvin Mermelstein	Plant Supervisor	Support	See Above	38,640	3	4.00%	Salary	9,660	L 6,C 1	2
3	Doreen Mermelstein	Administrative Asst.	Clerical	24.50%	65,885	16	26.00%	Salary	23,675	L 21, C 1	3
4	Henry Mermelstein	Administrative	Administrative	0.00%	180,000	416	10.00%	Salary	20,000	L 17,C 1	4
5											5
6											6
7											7
8					See Attached Schedule B						8
9											9
10											10
11											11
12											12
13								TOTAL	$ 89,675		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Emerald Park Health Care Center # 0040816 Report Period Beginning: 01/01/2000 Ending: 2/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Nivram Management, Inc.
Street Address: 2155 W. Pierce
City / State / Zip Code: Chicago, IL 60622
Phone Number: (773) 252-3208
Fax Number: (773) 252-3688

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Bank Charges	Resident Beds	942	5	$ 50	$	249	$ 13	1
2	21	Office Expeses	Resident Beds	942	5	361		249	95	2
3	21	Supplies	Resident Beds	942	5	7,772		249	2,054	3
4	43	Franchise Tax	Resident Beds	942	5	50		249	13	4
5	22	Payroll Taxes	Resident Beds	942	5	60,925		249	16,102	5
6	21	Telephone	Resident Beds	942	5	2,823		249	746	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 71,981	$		$ 19,023	25

Facility Name & ID Number Emerald Park Health Care Center # 0040816 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Mid-North		X	Mortgage	$35,230.00	01/01/1996	$ 2,995,849	$ 2,398,872	04/01/2010	0.1125	$ 278,796	1
2	Crawford		X	Mortgage	$8,826.00	01/01/1996	755,801	647,620	04/01/2012	0.1200	73,505	2
3	Diplomat		X	Mortgage	$26,440.00	01/01/1996	2,474,350	2,329,600	01/01/2019	0.1200	281,894	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$70,496.00		$ 6,226,000	$ 5,376,092			$ 634,195	9
	B. Non-Facility Related*											
10								Interest Income offset			(15,856)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (15,856)	14
15	TOTALS (line 9+line14)						$ 6,226,000	$ 5,376,092			$ 618,339	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Emerald Park Health Care Center # 0040816 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	267,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	266,222	2
3. Under or (over) accrual (line 2 minus line 1).	$	(778)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	274,200	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	273,422	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995	249,478	8
1996	257,687	9
1997	261,531	10
1998	259,589	11
1999	266,222	12

1999 Tax Bill - 266,222
Est Increase - 1.03
Est Tax - 274,208
Use - 274,200

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

Facility Name & ID Number Emerald Park Health Care Center # 0040816 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 68,426 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care		1996	$ 50,000	1
2					2
3	TOTALS			$ 50,000	3

Facility Name & ID Number Emerald Park Health Care Center # 0040816 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	249		1996	1976	$ 6,402,500	$	30	$ 213,417	$ 213,417	$ 911,119	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvement			1987	65,253		20	3,263	3,263	44,692	9
10	Building Improvement			1987	16,408		19	864	864	3,455	10
11	Building Improvement			1987	1,924		15	128	128	1,736	11
12	Building Improvement			1987	7,771		5			7,771	12
13	Building Improvement			1988	9,570		20	479	479	5,603	13
14	Building Improvement			1988	6,960		19	366	366	4,616	14
15	Building Improvement			1989	7,955		20	398	398	1,917	15
16	Building Improvement			1989	5,500		15	367	367	4,210	16
17	Building Improvement			1990	34,570		20	1,729	1,729	18,474	17
18	Electrical			1991	1,658		31.5	53	53	514	18
19	Elevator			1991	75,000		31.5	2,381	2,381	19,428	19
20	Remodeling			1991	3,668		31.5	116	116	1,049	20
21	Alarm Detection			1992	2,700		31.5	86	86	153	21
22	Curtains & Tracks			1992	16,416		31.5	521	521	4,363	22
23	Building Improvement			1993	63,956		39	1,640	1,640	13,377	23
24	Building Improvement			1994	3,221		39	83	83	539	24
25	Building Improvement			1994	3,500		39	90	90	585	25
26	Hot Water Heater			1994	1,985		39	51	51	331	26
27	Building Improvement			1995	9,054	357	39	232	(125)	1,276	27
28	Replace Floors in Entire Facility			1996	63,110	1,618	30	2,104	486	9,468	28
29	Wallpapering			1996	3,646	93	30	122	29	549	29
30	Drapery & Curtains			1996	12,244	314	30	408	94	1,836	30
31	Pavement - Driveway			1996	6,600	169	30	220	51	990	31
32	Remodeling Shower Rooms, Bathroom & Rehab Rooms			1996	171,960	4,410	30	5,732	1,322	25,794	32
33	New Lobbies & Nursing Station			1997	69,250	1,776	39	1,776		5,883	33
34	Kitchen Electrical			1997	3,578	92	7	511	419	1,579	34
35	Fire Door			1997	520	13	7	74	61	229	35
36	TOTAL (lines 4 thru 35)				$ 7,070,477	$ 8,842		$ 237,211	$ 228,369	$ 1,091,536	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Emerald Park Health Care Center # 0040816 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Air Conditioner			1997	2,205	57	39		(57)	199	9
10	Time Clock System			1998	4,958	127	39		(127)	318	10
11	Plumbing			1998	5,398	138	39		(138)	345	11
12	Air Conditioner			1998	4,239	109	39		(109)	272	12
13	Roof			1998	1,562	40	39		(40)	100	13
14	Tuckpointing			1999	1,917	10	39	49	39	74	14
15	Fire Alarm			1999	1,420	5	39	36	31	54	15
16	Fence			1999	3,367	86	39	86		129	16
17	Windows			1999	4,677	120	39	120		180	17
18	HVAC Work			1999	2,946	76	39	76		114	18
19	Painting			1999	42,104	10,311	7	6,015	(4,296)	9,002	19
20	Wallpaper			1999	4,804	1,177	7	686	(491)	1,029	20
21	Cubicle Curtains			1999	17,937	4,393	7	2,562	(1,831)	3,843	21
22	Drapes			1999	2,436	597	7	348	(249)	522	22
23	Carpeting			1999	2,788	683	7	398	(285)	597	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 102,758	$ 17,929		$ 10,376	$ (7,553)	$ 16,778	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Emerald Park Health Care Center # 0040816 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 539,392	$ 61,325	$ 53,940	$ (7,385)	10	$ 408,765	37
38	Current Year Purchases	9,111	1,823	456	(1,367)	10	456	38
39	Fully Depreciated Assets	249,000		49,800	49,800	5	224,100	39
40								40
41	TOTALS	$ 797,503	$ 63,148	$ 104,196	$ 41,048		$ 633,321	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 8,020,738	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 89,919	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 351,783	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 261,864	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,741,635	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Emerald Park Health Care Center # 0040816 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 16,398 Description: Ecolab - $3,359; Hertz(Windows) - $10,914; Ice Maker - $1,740; Oxyden $ 385
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Resident Care	Dodge Rambler Van	$ 690.00	$ 8,280	17
18	Administrative	1997 BMW	838.00	10,059	18
19	Administrative	1997 Honda Accord	309.79	3,717	19
20					20
21	TOTAL		$ 1,837.79	$ 22,056	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Emerald Park Health Care Center # 0040816 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

[ ] YES
[X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
COMMUNITY COLLEGE [ ]
HOURS PER AIDE ____

3. CLINICAL PORTION:

IN-HOUSE PROGRAM [ ]
IN OTHER FACILITY [ ]
HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2 Staff Units of Service	3 Staff Cost	4 Outside Practitioner (other than consultant) Units	5 Outside Practitioner (other than consultant) Cost	6 Supplies (Actual or) Allocated)	7 Total Units (Column 2 + 4)	8 Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10,Col 3	hrs	$		$ 2,076	$		$ 2,076	1
2	Licensed Speech and Language Development Therapist	L10A,Col 3	hrs			1,347			1,347	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10,Col 3	hrs			20,128			20,128	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39,Col 2	# of prescrpts				8,413		8,413	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$ 23,551	$ 8,413		$ 31,964	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Emerald Park Health Care Center # 0040816 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 322,613	$ 322,613	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,575,484	1,575,484	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	44,304	44,304	6
7	Other Prepaid Expenses	28,005	28,005	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Sch 17A	1,091,545	1,091,545	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,061,951	$ 3,061,951	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		50,000	13
14	Buildings, at Historical Cost		6,402,500	14
15	Leasehold Improvements, at Historical Cost	770,735	770,735	15
16	Equipment, at Historical Cost	548,503	797,503	16
17	Accumulated Depreciation (book methods)	(603,845)	(1,611,499)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Goodwill	266,523	266,523	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 981,916	$ 6,675,762	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,043,867	$ 9,737,713	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 153,185	$ 153,185	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	71,364	71,364	29
30	Accrued Salaries Payable	123,262	123,263	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	274,201	274,201	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Mgmt Fees	1,425,228	1,425,228	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,047,240	$ 2,047,241	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,376,092	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 5,376,092	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,047,240	$ 7,423,333	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,996,627	$ 2,314,380	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,043,867	$ 9,737,713	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,847,079	1
2	Restatements (describe):		2
3	**Prior Period Adjustments**	(17,073)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,830,006	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,071,621	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(905,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 166,621	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,996,627	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,923,468	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,923,468	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	24,670	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 24,670	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	20,367	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	6,684	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 27,051	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	15,856	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 15,856	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Bed Hold Income	158,018	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 158,018	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,149,063	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,152,587	31
32	Health Care	2,215,223	32
33	General Administration	1,329,494	33
	B. Capital Expense		
34	Ownership	1,235,523	34
	C. Ancillary Expense		
35	Special Cost Centers	8,613	35
36	Provider Participation Fee	135,977	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,077,417	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,071,646	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,071,646	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.**
Entity is a Cash Basis Taxpayer.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 57,215	$ 27.51	1
2	Assistant Director of Nursing	2,909	3,085	61,832	20.04	2
3	Registered Nurses	13,588	14,556	267,276	18.36	3
4	Licensed Practical Nurses	47,730	49,568	689,536	13.91	4
5	Nurse Aides & Orderlies	100,298	105,977	781,724	7.38	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,852	5,017	48,765	9.72	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	10,391	10,848	128,480	11.84	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,080	22,000	10.58	13
14	Head Cook					14
15	Cook Helpers/Assistants	27,843	30,159	194,908	6.46	15
16	Dishwashers					16
17	Maintenance Workers	1,796	1,825	37,529	20.56	17
18	Housekeepers	32,761	34,037	220,698	6.48	18
19	Laundry	9,030	9,720	67,932	6.99	19
20	Administrator	2,080	2,080	71,077	34.17	20
21	Assistant Administrator	657	657	36,340	55.31	21
22	Other Administrative	2,496	2,496	40,000	16.03	22
23	Office Manager					23
24	Clerical	15,936	16,296	201,121	12.34	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Bed Makers	8,827	9,211	67,503	7.33	33
34	TOTAL (lines 1 - 33)	285,354	299,692	$ 2,993,936 *	$ 9.99	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 8,800	L1, Col 3	35
36	Medical Director	Monthly	6,000	L9,Col 3	36
37	Medical Records Consultant		4,032	L10,Col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,628	L10,C0l 3	39
40	Physical Therapy Consultant	38	1,757	L10A,Col 3	40
41	Occupational Therapy Consultant	71	3,244	L10A,Col 3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	39	1,796	L12, Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	148	$ 27,257		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Catherine Joseph	Administrator	0.00%	$ 71,077
Hanry Mermelstein	Administrative	0.00%	20,000
Marvin Mermelstein	Asst. Administr	24.50%	36,340
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 127,417

B. Administrative - Other

Description	Amount
Management Fees - Eliminated in Col. 7	$ 98,955
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 98,955

C. Professional Services

Vendor/Payee	Type	Amount
Altschuler, Lelvoin & Glasser	Accounting	$ 4,200
American Express Tax	Accounting	6,300
Kessler, Orlean, Silver & Co.	Accounting	3,150
See Attached		141,619
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 155,269

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 38,416
Unemployment Compensation Insurance	42,494
FICA Taxes	219,560
Employee Health Insurance	29,527
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union Health & Welfare	99,996
Other Employee Benefit	11,257
Allocation from Management Comapany	16,102
TOTAL (agree to Schedule V, line 22, col.8)	$ 457,352

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	6,630
Health Care Worker Background Check	1,548
(Indicate # of checks performed 129)	
IL Council on Long Term Care	9,680
See Attached Schedule	9,139
IL Assoc of Health Care Facility	249
Less: Public Relations Expense	( )
Non-allowable advertising	(6,630)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,616

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	710
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 710

* Attach copy of IMRF notifications

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
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9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Emerald Park Health Care Center # 0040816 Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on Long Term Care $9,680**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,931** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **135,977**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **75,396** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Adequate Records are Maintanined**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees